In The Matter Of:

JOHN AND MARTHA RUFFINO v.

DR. CLARK ARCHER and HCA HEALTH SERVICES OF TN, et al.

CAROL McCULLOCH, RN

November 29, 2017

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IN THE UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF TENNESSEE
NASHVILLE DIVISION

JOHN RUFFINO and MARTHA RUFFINO, Husband and Wife,

Plaintiffs,

vs.

DR. CLARK ARCHER and HCA HEALTH SERVICES OF TENNESSEE, INC. d/b/a STONECREST MEDICAL CENTER,

Defendants.

CASE NO. 3:17-CV-00725

DEPOSITION OF:

CAROL McCULLOCH, RN

Taken on behalf of the Plaintiffs

November 29, 2017

APPEARANCES:

For the Plaintiffs:

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I N D E X

INDEX OF EXHIBITS

The deposition of CAROL McCULLOCH, RN, was taken by counsel for the Plaintiff, on November 29, 2017, commencing at 1:49 p.m., in the offices of Gideon, Cooper & Essary, PLC, 315 Deaderick Street, Suite 1100, Nashville, Tennessee, for all purposes under the Tennessee Rules of Civil Procedure.

The formalities as to notice, caption, certificate, et cetera, are not waived. All objections, except as to the form of the questions, are reserved to the hearing.

It is agreed that Carissa L. Boone, being a Notary Public and Court Reporter, may swear the witness, and that the reading and signing of the completed deposition by the witness are not waived.

* * *

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CAROL McCULLOCH, RN,
having been first duly sworn, was examined and testified as follows:

EXAMINATION

BY MR. CUMMINGS:

Q. Ma'am, please tell us your full name.
A. Carol McCulloch.
Q. How do you spell your last name?
A. It's M-c-C-u-l-l-o-c-h.
Q. My name is Brian Cummings. I'm going to ask you some questions about a patient in StoneCrest's ER back in February 2016.
A. Okay.
Q. Do you remember a patient named John Ruffino?
A. No.
Q. Do you currently work as a nurse?
A. No.
Q. Did you retire?
A. I retired almost a year ago. Last December.
Q. For about how many years did you work as a nurse?
A. I worked as a nurse for 48 years, 46 of those with HCA.

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Q. What is HCA?
A. What is it?
Q. Yes, ma'am. When you say you worked 46 years --
A. Oh, I'm sorry.
Q. -- for HCA, what is HCA?
A. Well, you made me go blank there.
Q. Well, what did it mean when you said it?
A. It's the company I worked for.
Q. Okay. And when you worked in the StoneCrest ER in February 2016, you worked for HCA?
A. Yeah, it's a -- it's one of the hospitals with HCA.
Q. Okay.
A. With the corporation. Hospital Corporation of America, that's what it stands for.
Q. How many years did you work at StoneCrest?
A. I think it was 14. I started working there when they opened.
Q. I was just going to ask that. It almost had to be if it was 14 years, right?

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A. Right. What it -- I think it was 14 years that they -- or maybe 15 years now, I guess.
Q. Did you work in the ER the entire time you worked at StoneCrest?
A. Yes, sir.
Q. Did that mean by February 2016 you were familiar with the policies and procedures regarding stroke patients --
A. Yes, sir.
Q. -- that existed for the StoneCrest ER?
A. Yes, sir.
Q. What do you remember about those policies and procedures?
A. Any specific one, or what do you mean? You said with a stroke?
Q. Yes, ma'am.
A. Well, we had a -- what we called a Code Stroke policy that -- it was just a -- we could announce that would start things moving a little faster as far as when a patient arrived.
Q. If a patient arrived at the ER and a healthcare provider thought that patient was having a stroke or recently had the acute

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onset of a new stroke, a Code Stroke could be called?
A. Yes.
Q. What would your role as a nurse be in getting a Code Stroke called for such a patient?
A. Well, I would notify -- I would make sure there was a physician or a provider there, being a nurse practitioner or....
Q. Do you --
A. And --
Q. Go ahead, ma'am.
A. And my role as a nurse would be to get the -- get the patient to CT as soon as possible.
Q. Why would you want to get a stroke patient to CT as soon as possible in an ER setting?
A. To see what further treatment we needed.
Q. And what would a CT scan of the head tell someone about what further treatment was needed for a stroke patient?
A. Well, depending on what they find.
Q. If that CT was negative or normal,

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what would happen?
A. There would be a re-evaluation of the patient by the physician. Then he would decide at that point if there needed to be further studies done.
Q. And when you say "he," you mean the doctor?
A. The doctor, yes.
Q. If you -- if I use the term "triage," is that a term you're familiar with?
A. Yes.
Q. If you triaged an ER patient and felt they might be in the midst of a new stroke, could you notify a doctor or a nurse practitioner to help get a Code Stroke initiated?
A. Yes.
Q. And in your time working in the StoneCrest ER for ten-plus years, did you ever see an ER patient who you triaged and felt was in the midst of a recent stroke?
A. Did I --
Q. Yes, ma'am.
A. -- ever see one?
Q. Yes.

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A. Yes.
Q. Instead of this just being theoretical, did you actually do that at times?
A. Yes.
Q. And you would decide, based on what you found in examining the patient or evaluating a patient, whether to get a doctor or a nurse practitioner involved to potentially call a Code Stroke, correct?
A. Right. But during the triage, we usually had a doctor or a nurse treating the patient at the same time.
Q. Okay. There's a stack of records to your right side that have page numbers in the lower right. Can you turn --
A. This one (indicating)?
Q. Yes, ma'am.
A. This one (indicating) or this one (indicating)?
Q. Mr. Carter might be able to help us with that.
A. Are they the same?
MR. CARTER: They're the same.
THE WITNESS: Oh, okay.

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BY MR. CUMMINGS:
Q. If you use those page numbers, will you please turn to Page 11.
A. (Witness complies.) Okay.
Q. Are you there?
A. Yes.
Q. Do you see the assessment you did that you documented at 9:58 in the morning on February 17th?
A. On 11?
Q. It's the left hand -- yep.
MR. CARTER: (Indicating.) We're using this page and he's using that page. That's my fault. She was on Bates-stamp No. 21.
MR. CUMMINGS: Okay.
THE WITNESS: Okay. I was going to say that didn't look like my charting.
MR. CARTER: When he says "Bates-stamp number," he's talking about --
THE WITNESS: Down here (indicting)?
MR. CARTER: Yeah.
THE WITNESS: Okay. Sorry.
MR. CARTER: No, we're good.

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THE WITNESS: I saw these numbers over here first.
BU MR. CUMMINGS:
Q. Are you on Page 11?
A. Now I'm on Page 11 down -- this 11. Okay.
Q. Do you see in the left-hand column your note that you made at 9:58 in the morning on February 17th? There's a recorded time.
A. Right here (indicating)? Okay.
Q. Do you see that now?
A. I do now.
Q. And you entered the Occurrence Time as 9:56 that same day, correct?
A. Yes.
Q. What would you tell us this note is? What does it represent?
A. The Rapid Initial Assessment, which is the triage note. Would be the first assessment of the patient when they arrived.
Q. Okay. Is that --
A. After they arrived.
Q. Is that the name of this note?
A. Rapid Initial Assessment, I think, is

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the name of it.
Q. Okay.
A. It's up there at the very top.
Q. And that's what I was looking at, and maybe we're not on the same page. My copy of Page 11 for the note you made at 9:58 that day says "Rapid Initial Assessment with Sepsis" at the top. Do you see that?
A. Uh-huh.
Q. Is that a "yes"?
A. Yes.
Q. Why is it when I asked you what this note was called, you didn't mention the "with sepsis"?
A. Because I did the Rapid Initial Assessment. I don't -- I don't know.
Q. This patient didn't have sepsis, did he?
A. I don't know.
Q. Well, who chose to use the Rapid Initial Assessment with Sepsis note?
A. I -- I think that's the way the -- it comes up with every patient.
Q. Every patient's initial assessment note in the StoneCrest ER in February 2016

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would say Rapid Initial Assessment with Sepsis at the top?
A. I think so. I....
MR. CARTER: If you don't --
THE WITNESS: I don't know.
MR. CARTER: -- know, just say "I don't know."
THE WITNESS: I don't know that for sure, but I know that that was something that would come up because we would assess that at some point --
BY MR. CUMMINGS:
Q. Okay.
A. -- on everybody.
Q. Do you think this note includes a severe sepsis screening? And you might see it in the right column midway down.
A. It does.
Q. Okay. Why was Mr. Ruffino screened for sepsis as part of the initial assessment in the ER that day?
A. Why was he?
Q. Yes, ma'am.
A. I think that was -- I -- I think that's on every patient that we did.

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Q. Okay. So in your 14 years or so of working in the StoneCrest ER, your initial assessment of every ER patient at StoneCrest included a severe sepsis screening?
A. After a certain time. Not from the very beginning, but after a certain time, yes.
Q. What does it mean when you say "after a certain time"?
A. Well, when sepsis became a -- when it became that sepsis needed to be addressed right away. The sooner the better. That wasn't always -- that wasn't always the case.
Q. Did you choose some option that led to this note being in the form or format called Rapid Initial Assessment with Sepsis?
A. Did I chose that?
Q. Yes, ma'am.
A. There was a way you put the patient in initially to get them into the computer, and I don't know what it was called.
MR. CARTER: That's fine. Just tell him what you remember.
THE WITNESS: It's been a while. But you chose -- there was one -- one form

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that you went -- one spot you went to, and I don't remember the name. I don't know if it was -- that was the name initially, but you put in the patient's information to get them in to the computer.
BY MR. CUMMINGS:
Q. What do you think you put in to the computer about Mr. Ruffino that led to this note being entitled Rapid Initial Assessment with Sepsis?
A. I think that comes up with every patient.
Q. Okay. Does this note indicate to you that you were the first point of contact with this patient?
A. As far as I -- yes, looking at this. That would be the first charting, first -- the first assessment.
Q. Well, I'm being simpler than maybe you appreciate. The very first line of this note says: "First point of contact," and then says "Yes," correct?
A. Oh, okay.
Q. And this is your note?
A. Yes.

Q. Do you think you were the first point of contact with this patient at the ER that day?
A. As far as I know, I was. According to what I charted here.
Q. Okay. And you would rely on what you charted as being accurate, correct?
A. Yes.
Q. You documented the patient arrived by ambulance, right?
A. Okay. Yes.
Q. Do you believe that's accurate?
A. If I charted it.
Q. Okay. Under Subjective Assessment, you typed: "Reported dizziness while driving. History of seizures."
Do you see that?
A. I do.
Q. Okay. Will you tell me if there's anything in this note -- and take as long as you need to read it -- that Mr. Ruffino told you that he was having dizziness while he was in the ER, rather than he had dizziness when he was driving?
A. Can I read the note?

Q. Please, yeah. And I thought I just encouraged you to do that, but please do so.
A. Okay. (Witness reviews document.) No, nothing.
Q. If Mr. Ruffino had complained to you of dizziness while in the ER, you would have documented it, correct?
A. Yes, I would have.
Q. Look at the Chief Complaint that you documented in this note. It's in the left-hand column about where your fingers just were.
A. "Vertigo/dizziness."
Q. The way vertigo/dizziness is listed there, is that something chosen from a menu, or did you type that?
A. It's chosen from a menu.
Q. Okay. Do you know whether vertigo/ dizziness was chosen incorrectly from a menu if you didn't type it?
A. If it was chosen incorrectly?
Q. Yes, ma'am. Or you can tell me you never make mistakes in documentation, and I'll rely on that.
A. Well, I won't say that I never made a

mistake in documentation, but we had to choose -- when you put in a chief complaint, you had to choose something, some kind of, like say it was a list, and "Vertigo/ Dizziness" I chose as being the closest thing to his complaint.
Q. Okay. What was the complaint he told you he was having in the ER, if you remember?
A. Apparently nothing, according to my charting.
Q. Okay. And then let's look at the right-hand column. Do you see the vital signs you documented?
A. Uh-huh.
Q. Is that a "yes," just so she can type it?
A. Yes. Oh, I'm sorry.
Q. It's okay. Everybody does that.
A. Yes.
Q. Okay.
A. And the respirations are obviously incorrectly documented.
Q. Did you know that before we started the deposition?
A. No.

Q. Okay. What does it mean to you if the respirations you documented as part of this initial assessment is incorrect?
A. Well, it's an impossible number to count, 189 respirations. You wouldn't be alive. I don't know that anybody can breath that fast.
Q. So how would you --
A. That is a number I do type in with my fingers. And 8 and 9 are next to each other. It's easy to hit the next key. And I -- I'm sure I've done that before.
Q. What do you think is the best explanation for why you documented the respiration rate was 189 as part of your initial assessment?
A. I just hit an extra key.
Q. Okay. Do you know what the actual respirations you meant to document were?
A. Probably 18, because normal is 18 to 20, 22.
Q. Okay. Have you ever thought that a normal respiratory rate was 16 to 20?
A. I mean, 16 could be normal, too.
Q. I'm just asking you. I've never

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worked 40 years as a nurse. Do you think -- have you ever thought that 16 to 20 has been considered a normal respiratory rate?
A. Well, it can be.
Q. Okay. When you would obtain a patient's respiratory rate for this kind of assessment, how would you do it, whether it was with a monitor or some other device?
A. Sometimes with a monitor and sometimes I actually would count using my watch.
Q. Which method do you think you used, just based on your habit that existed as of February 2016?
A. Probably by the monitor. Because our monitors, it's just an observation of -- they would look pretty normal in his breathing, according to the rest of this. That he was -- his color was good, and he was awake and alert.
Q. If you --
A. He was -- he was normal otherwise.
Q. From looking at this note and presuming the respiration rate is incorrect, just incorrect as it's typed or --
A. Uh-huh.

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Q. -- for whatever reason, would you characterize the patient who this note corresponds to as appearing relatively normal at the time of the assessment?
A. Would you ask that again?
Q. Sure. Based on what you documented in this initial assessment note, does it appear Mr. Ruffino was relatively normal at the time of this assessment?
A. Yes.
Q. Is there anything you can tell me that was abnormal at the time of your assessment of him in the ER at about 9:56 on February 17th?
A. His blood pressure was a little bit high.
Q. Okay. Anything else abnormal?
A. No.
Q. Do you see in the left-hand column -- and I think your answers to this section are in caps -- where you documented an Objective Assessment?
A. Okay.
Q. Do you see that?
A. Uh-huh. Yes.

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Q. And you documented: "Awake and alert. Color good. Moving all extremities," correct?
A. Yes.
Q. Do you agree that everything you documented for his Objective Assessment was good or normal?
A. Yes.
Q. Did you document a single abnormal objective finding in your Objective Assessment?
A. An abnormal one? No.
Q. Do you see the Priority Item a few lines down from where we're looking?
A. Yes.
Q. What does it say after Priority?
A. "Urgent."
Q. Well --
A. 3 -- "CTAS 3/urgent."
Q. There we go.
A. Okay.
Q. "CTAS 3/urgent," right?
A. I just moved to my nursing part, I'm sorry.
Q. That's okay. At this point, this is

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just a reading quiz, okay?
A. Okay.
Q. What does "CTAS" stand for in this note of yours?
A. I don't know what the CTAS is. Three is -- every patient was assigned a category, 1 through 5.
Q. Okay. Was 1 the most severe category or the least severe?
A. One was the least severe.
Q. Okay. Either way, 3 is middle of the road?
A. Three is right in the middle.
Q. Understood. "Urgent" is a term that in normal society sounds like a big deal.
A. Right.
Q. Where did "Urgent" fall with regards to ER patient priority?
A. Well, I'll have to kind of go backwards. Five was the most severe. That would be somebody that we were resuscitating.
Q. Okay.
A. Four would be somebody that needed something right now, can't wait or they will be resuscitating. Or possibly. And 3 was

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they need -- they need care and they need to be taken care of, but we've got just a little bit of time to do it.
Q. Okay.
A. And I don't remember -- there were numbers there how much time, but I couldn't tell you right now.
Q. Understood. And you determined what this patient's priority was based on your initial assessment, right?
A. Yes.
Q. And you felt he needed care but not immediately, right?
A. Yes.
Q. If you felt he was in the midst of a new stroke at that time, you would not have classified him as Class 3, would you?
A. No.
Q. So is it fair to say that the way you classified him, based on your initial assessment on February 17th, that you did not think he was in the midst of a stroke or had recently had the onset of an acute stroke?
A. Ask me that again.
Q. Sure. Based on the fact you

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documented him as what I'm calling a Class 3 --
A. Okay.
Q. -- do you agree that that means you did not think he was having a stroke at the time?
A. Yes.
Q. Because if you thought he was having a stroke when you did the initial assessment --
A. Yes.
Q. -- you would have assigned him a 1 or 2 priority status, correct?
A. Probably a 4. It goes the other way.
Q. Five is the worst?
A. Five is the worst.
Q. Okay.
A. He would have probably been a 4.
Q. Okay. And a priority status 4, if you would have assigned that to Mr. Ruffino, would have meant what?
A. To be seen right away, and he would have priority over other patients that might could wait an hour or so.
Q. On February --
A. And like I say, I don't remember the

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exact amount of time. I don't remember that part, but....
Q. On February 17th, 2016 when you saw Mr. Ruffino, could you have assigned him any priority status you wanted if it matched what you saw on your initial assessment?
A. Yes.
Q. And do you stand by the priority status you assigned to Mr. Ruffino, based on what you saw on February 17th, based on at least 40 years of nursing experience?
A. Yes, I do.
Q. And by February 17th, 2016, how many years had you worked as an ER nurse? Not just at StoneCrest, because you gave me that, but the bigger number.
A. Probably another 15 years.
Q. Is it fair to say, then, that by February 17th, 2016, you had approximately 30 years' experience working as an ER nurse?
A. Yes.
Q. And by February 17th, 2016, you were experienced and fully competent to recognize if an ER patient you're assessing had any signs or symptoms of a stroke?

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A. I do.
Q. If you had any reason to think Mr. Ruffino was having a stroke and a new stroke when you saw him, would your documentation read differently?
A. Yes.
Q. And in what way would it read differently?
A. Well, I would put any symptoms he was having, such as not able to talk or not being able to move an extremity, weakness.
Q. Would his priority status also be different?
A. Yes.
Q. Would your note also indicate that maybe you had reached out or notified a physician?
A. Possibly.
Q. If you thought a Code Stroke had to be called, you'd have to reach out to a physician?
A. Yes.
Q. Okay. If you observed any neurological deficits during your initial assessment, would it be in your note?

A. Yes.
Q. Do you agree there are no neurological deficits documented?
A. I agree.
Q. And do you agree that based on what your note tells you, you know that you didn't find a single neurological deficit in your initial assessment of Mr. Ruffino?
A. I agree.
Q. Do you remember speaking with any doctors about Mr. Ruffino that day?
A. No. I --
Q. Do you remember --
A. -- I don't remember.
Q. Understood. I don't know unless I ask you.
A. That's fine.
Q. Do you remember speaking with any doctors about -- or nurse practitioners about Mr. Ruffino after this day?
A. After this day?
Q. Yes, ma'am.
A. No. I don't remember talking to them about, you know -- this case particularly, that's what you're saying?

Q. To me "case" is something that means there's a lawsuit filed in a building.
A. Oh.
Q. I wasn't trying to limit it to that.
A. Okay.
MR. CARTER: And she's trying to make sure you're not asking about talking to the other nurses involved in the care ever. So y'all are just missing each other.
THE WITNESS: Okay. Ask it --
BY MR. CUMMINGS:
Q. Have you ever --
A. Ask it again.
Q. Sure. And that's a great thing for you to say to me.
Have you ever spoken with a nurse practitioner or a doctor about Mr. Ruffino, after February 17th, 2016?
A. No.
Q. From your awareness of your experience with stroke patients by February 2016 and your note, do you have any reason to think Mr. Ruffino was having a stroke at the time of your initial assessment and you missed it?
A. No.

Q. Those are all my questions.
Thank you.
MR. WITT: No questions.
EXAMINATION
BY MR. CARTER:
Q. I have one short series.
You testified at the very beginning of this deposition that you had worked for hospitals that HCA owned for 46 years, I think was your testimony. Do you recall that?
A. Yes.
Q. You understood in February 2016 that you were actually employed by StoneCrest, correct?
A. Yes.
Q. You didn't believe that you were employed by HCA directly, right, or did you know?
A. Well, I worked for StoneCrest --
Q. Okay.
A. -- which is part of HCA.
Q. Your understanding is HCA is the entity that owns StoneCrest, but you were employed by StoneCrest?

A. Yes.
Q. Okay. Good enough.
MR. CARTER: No further questions. We'll read and sign.
THE COURT REPORTER: Brian, are you going to order all of these?
(Discussion off the record.)
MR. CUMMINGS: I definitely want the transcripts. Electronic everything.
(Discussion off the record.)
THE COURT REPORTER: And are you going to order all of them as well?
MR. WITT: I guess I will, yeah, all three.
(Discussion off the record.)
THE COURT REPORTER: And you want all three, a copy of all three, right?
MR. CARTER: Yes, I am.
FURTHER DEPONENT SAITH NOT.
(Proceedings concluded at 2:18 p.m.)

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REPORTER'S CERTIFICATE

I certify that the witness in the foregoing deposition, CAROL McCULLOCH, RN, was by me duly sworn to testify in the within entitled cause; that the said deposition was taken at the time and place therein named; that the testimony of said witness was reported by me, a Shorthand Reporter and Notary Public of the State of Tennessee authorized to administer oaths and affirmations, and said testimony, Pages 5 through 33 was thereafter transcribed into typewriting.

I further certify that I am not of counsel or attorney for either or any of the parties to said deposition, nor in any way interested in the outcome of the cause named in said deposition.

IN WITNESS WHE

set my hand this 8th d

_____
Carissa L. Boone, LCR No. 382
My License Expires: 6/30/2018

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E R R A T A

I, CAROL McCULLOCH, RN, having read the foregoing deposition, Pages 5 through 33, taken November 29, 2017, do hereby certify said testimony is a true and accurate transcript, with the following changes (if any):

PAGE	LINE	SHOULD HAVE BEEN	REASON
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_____
CAROL McCULLOCH, RN

_____
Notary Public
My Commission Expires: _____